

Release of Information

I _____ Date of Birth _____

Authorize: _____

to disclose the following medical treatment information

to _____

for care provided to: _____

on these dates: _____

The information released will be used for the following purpose:

Medical Treatment

I specifically authorize the release of the following:

Entire record Only those items listed below:

Drug/Alcohol Abuse Treatment

Psychiatric and Mental Illness Treatment

Human Immunodeficiency Virus (H.I.V.) Antibody Test, Results,
and Treatment Information

Registration Record

History and Physical

Operative Report

X-Ray Report

EKG Report

Lab Report

Visit/Encounter Notes

Billing records

Other-Specifically: _____

I expressly and voluntarily authorize disclosure of the above medical record for the purposes stated above. I further understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

This release is effective for 90 days from the date signed, unless otherwise specified as follows: _____

I understand that the parties in receipt of these records may not further disclose the medical information unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

Signature of Patient/Date

SSN, Date of Birth, and Other Names Used

Parent, Guardian, or Legal Representative/Date
(State Your Relationship to the Patient)